Behavioral Health Care, P.C.

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CONSENT FOR PYSCHOTROPIC MEDICATION

Patient Name:___________________________

Date of Birth: __________________________

MEDICATION: _________________________ Anti-depressant Mood Stabilizer Anti-psychotic
Anti-anxiety Psychostimulant

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- I understand that this medication is being ordered to treat my/my child's symptoms of a mental or emotional illness. My physician thinks that use of this medication at this time may help manage my/my child's illness. I understand that the medication may not work. My healthcare provider discussed other treatment options with me.
- I understand that my/my child's response to this medication will be assessed to determine it is working and it will be stopped when it is not needed or stops working. It will be ordered in the lowest dose possible.
- I understand that all medications may cause side effects, and that some side effects may be serious or permanent. I have received oral and written information about this medication. I understand that I must report side effects or unusual reactions to my doctor. I have read and understand the written material explaining the medication I/my child will be taking. I have been able to ask questions so that I can understand what I need to know.

- I have told my doctor about my medical conditions, medications I take now, and medication reactions I have had in the past.
- I understand the importance of taking this medication the way it was ordered by my doctor.
- I understand that I may need blood test or cardiograms, and that my height, weight and blood pressure may be monitored. If any other tests are needed, my doctor will talk to me first. I agree to follow these recommendations.
- I agree to take this medication and know that I may stop taking it any time without affecting my future care.

_____	_____	_____	_____
Patient/Guardian Signature	Date	Time	Print Name
_____	_____	_____	_____
Witness for Authorization	Date	Time	Print Name
_____	_____	_____	_____
Physician's Signature	Date	Time	Print Name (Physician)